

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

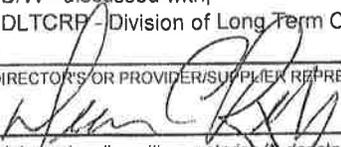
PRINTED: 06/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085025	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/04/2015
NAME OF PROVIDER OR SUPPLIER CHURCHMAN VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 4949 OGLETOWN-STANTON ROAD NEWARK, DE 19713	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>An unannounced complaint survey was conducted at this facility from 4/30/15 through 6/4/15. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 90. The survey sample size was three (3).</p> <p>Abbreviations/definitions used in this 2567 are as follows:</p> <p>NHA - Nursing Home Administrator; DON - Director of Nursing; NP - Nurse Practitioner; CRC - Clinical Resource Coordinator; UM - Unit Manager; RN - Registered Nurse; LPN - Licensed Practical Nurse; CNA - Certified Nurse's Aide;</p> <p>ADL - Activities of Daily Living, tasks needed for daily living such as dressing, toileting, bathing and eating; amb - ambulatory, walking; anterior - front; augmented - increased; BID - twice a day; BKA - below the knee amputation; Bactroban - topical ointment for wounds; c - with; c/o - complaint of; cellulitis - inflammation of the tissues indicating a local infection; d/c - discharged; D/W - discussed with; DLTCRF - Division of Long Term Care Residents</p>	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE



ADMINISTRATOR

REVISED 7/1/15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 Protection, state regulatory agency; dys - dysfunction; Diabetes - disease where blood sugar levels are high; HEP - Home Exercise Program; Hoyer lift - total mechanical lift; Hypertension - high blood pressure; I - independent; i.e. - such as; lbs - weight in pounds; L - left; LE - lower extremity; LLE - left lower extremity; MDS - Minimum Data Set, standardized assessment form used in nursing homes; NWB - non-weight bearing; OT - Occupational Therapy; PLOF - Prior Level of Functioning; pt - patient; PT - Physical Therapy; peripheral neuropathy - disease affecting nerves often causing weakness, numbness and pain in the hands and feet; re - regarding; rx - prescription; sedentary - inactive; stasis - decreased blood circulation; TAR - Treatment Administration Record; theraband - resistance exercise tool to increase strength; UE - upper extremity; w/ - with; WB or WBing - weight bearing; wc - wheelchair; wt or wgt - weight.	F 000		
F 207 SS=D	483.12(c) EQUAL PRACTICES REGARDLESS OF PAYMENT SOURCE	F 207		

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F 207	<p>Continued From page 2</p> <p>A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all individuals regardless of source of payment.</p> <p>The facility may charge any amount for services furnished to non-Medicaid residents consistent with the notice requirement in §483.10(b)(5)(i) and (b)(6) describing the charges; and the State is not required to offer additional services on behalf of a resident other than services provided in the State plan.</p> <p>This REQUIREMENT is not met as evidenced by: Cross refer to F309, example 1a.</p> <p>Based on observation, record review and interviews, it was determined that for one (R1) out of 3 sampled residents, the facility failed to ensure that R1 was not treated based on his source of payment when providing services. Findings include:</p> <p>In an interview on 5/8/15 at 7:17 AM, E5 (UM, RN) stated that she was interested in when R1 went from "skilled to pink". When asked what she meant, E5 explained that there was a color label on the outside of the resident's chart to indicate if there was a payer source or not. E5 stated green was managed care, yellow was Medicaid, blue was Medicare, white was private pay and pink was no payer source. E5 stated when R1's 30 days were exhausted (occurred mid-March) and he did not leave the facility, that's when E1 (NHA) made him a non-payer source. E5 stated that when the nurses see a pink label, they feel they</p>	F 207	<p>F207</p> <p>A- R1 has been discharged to home from the facility.</p> <p>B- No other residents were affected by this practice. All current residents charts were audited and no current residents have pink label identifying, "no payor" source.</p> <p>C- Director of Nursing (DON)/designee will educate licensed nurses and unit clerk on the new chart label system and educate on right to care regardless of payor source by 7/31/15. New chart system change will not consist of no payor source as an identifier. Business office manager/designee will initiate chart label system and monitor charts to ensure that a no payor source label is not an identifier.</p> <p>D- DON/designee Monitor a sample of 5% of resident charts daily until consistently reach 100% compliance over 3 daily consecutive evaluations. Then monitor 5% of resident charts weekly until consistently reaching 100% success for 3 evaluations, then monitor monthly until consistently reaching 100% success over 3 consecutive evaluations. If 100% is reached, conclude that successful achievement of problem has been addressed. Review at quarterly quality assurance meeting</p>	07/31/2015

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F 207	Continued From page 3 should not have to document since it's not a blue label. When asked if that meant he stopped getting care, E5 stated they never stopped giving care, he refused care, i.e. refused to get out of bed and go to the dining room. E5 stated remember on 4/7, R1 had no payer source and asked how PT can see him if there is no payer source. She felt the facility was going over their boundaries with having no payment for services. E5 asked this surveyor if S2 (foot doctor) knew that R1 had no payer source. This surveyor replied that S2 was under the impression that R1 was receiving PT here at the facility per his orders. E5 stated he was getting nursing care, but would not be entitled to physical therapy since the facility was not being paid. Review of the clinical record revealed that the facility failed to provide PT to R1 from 4/6/15 through 5/1/15 despite two physician orders dated 4/6/15 and 4/20/15 for PT. An observation on 5/8/15 at approximately 12:10 PM revealed a pink label on the outside of R1's chart, confirming E5's statement above. In an interview on 6/4/15 at 1:49 PM, E1 (NHA) stated the colored labels were used to assist the unit clerk to arrange services for residents, i.e. transportation, according to their payer source. The facility failed to ensure that R1 was not treated based on his source of payment when providing services that are required under the law. Findings reviewed with E1 and E2 (DON) on 6/4/15 at approximately 5:30 PM.	F 207		
F 223 SS=D	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION	F 223		

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F 223	Continued From page 4 The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Cross refer to F309, examples 1a and 1b. Based on observation, record review, interviews and review of facility documentation, it was determined that for one (R1) out of 3 sampled residents, the facility failed to protect R1's right to be free from abuse when R1 felt threatened and intimidated by a staff person in a supervisory role and deprived of goods and services when his requests for physical therapy, transfer assistance and a different staff person to wrap his leg were disregarded. Findings include: The facility's policy entitled "Abuse Prohibition", last revised on 12/1/11, stated, "... Adult abuse is defined as: ... Emotional abuse which includes, but is not limited to, ridiculing or demeaning a patient, making derogatory remarks to a patient ... or threatening to inflict physical or emotional harm on a patient ...". 2/17/15 - R1 was admitted to the facility for short-term rehabilitation, including PT. Diagnoses included a right BKA, diabetes and hypertension. His admission weight was 305 lbs. 2/24/15 - The admission MDS assessment stated	F 223	F 223 A- E5 was educated on resident's rights and abuse prohibition. E5 attended management 101 training. B- No allegations of abuse are reported by any other residents, family or employees. The Social Worker will attend resident council meeting by 7/23/2015 and present resident rights and reporting concerns of abuse. Facility department managers will complete interviews of 20 % of in house resident to identify and follow-up any areas of concern reported by residents or families. "No payor source" labels were reviewed, and removed from the records. Current process changed to remove the "no payor source" as an identifier C- 1) Director of Nursing (DON)/designee will review transfer and Hoyer lift policy and procedure. After policy review, competency will be administered to all nursing staff, those not passing will receive remedial training by 7/31/2015 2) DON/designee will educate licensed nurses and unit clerk on the new chart label system and educate on right to care regardless of payor source. "Refer to plan of correction for F207" 3) Social Worker/designee will review grievance process with all staff 7/31/15. Process will include utilization of grievance/concern form. Form will be communicated with Social worker and appropriate department for follow-up. Follow-up to all grievances will be discussed at morning meeting. 4) DON/designee will educate all licensed nursing staff on proper follow-up documentation with treatment completion. Unit Managers/designee will review treatment/mar records daily for omission of initials and follow-up with nurses as necessary	07/31/2015

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F 223	<p>Continued From page 5</p> <p>that R1 was able to make his own decisions.</p> <p>Review of R1's clinical record from admission on 2/17/15 through 4/23/15 revealed the absence of grievances or complaints. In fact, nurse's notes during this timeframe captured R1 as able to make his needs known, pleasant, cooperative and thankful for care from staff.</p> <p>4/30/15 at 6:52 PM - Surveyors interviewed the resident, R1, in the presence of S6 (family member). R1 stated the following:</p> <ul style="list-style-type: none"> - He felt threatened and intimidated by E5 (UM, RN). - "The only issue I have is with one nurse (E5) and she is a 7 to 3 pm ... At 7:00 in the morning, I am on my guard at least." - He had been asking for assistance with transfers and asking for physical therapy the week of 4/27/15. He asked E5 for transfer assistance with a lift, which was refused. He asked E5 three (3) times to talk to PT. - "I have one leg to transfer with ... I think it is unsafe ... I am staying here (in his room) because ... unsafe transfer." - On 4/28/15 around lunchtime, E5 told him "you will be eating outside this room tomorrow". R1 interpreted this to mean that he may not receive his meal if he stayed in his room. R1 is a diabetic and requested that S6 bring him food. S6 delivered food but R1 also confirmed that his meals were delivered to his room by the facility. - "... I asked for a different nurse to wrap my leg ... she says 'it's either me or no one' ... she is stating that I refused which I have never refused." - E5 refused to provide her last name when asked. R1 has vision problems and was not able to read her name tag. 	F 223	<p>F 223 (cont)</p> <p>5) DON/designee will educate all licensed staff and rehab on new communication process. Communication process will consist of initiation of referral form to appropriate discipline. Once reviewed and/or signed by attending, all consults and orders will be brought to morning meeting to review accuracy and follow-up with appropriate discipline.</p> <p>6) DON/designee will educate all licensed staff on proper procedure when discontinuing or clarifying orders. Review orders daily to ensure follow-up and discontinued appropriately</p> <p>D-DON/designee monitor a sample of 5% of each identified deficient practice daily until we consistently reach 100% success over 3 daily consecutive evaluations. Finally, monitor sample weekly until consistently reaching 100% success for 3 evaluations, then monitor monthly until consistently reaching 100% success over 3 consecutive evaluations. If 100% is reached, conclude that successful achievement of problem has been addressed. Review at quarterly quality assurance meeting</p>	

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F 223	<p>Continued From page 6</p> <ul style="list-style-type: none"> - S6 (family member) stated, "... really bothered me was when E5 told me like three (3) weeks ago S1's (wound care doctor) order expired and that she was going to stop wrapping his leg, so I had to take R1 back to S1's office to get S1 to write a lifetime order because they (the facility) were supposed to wrap his leg here twice a day and they never did it ...". <p>Review of R1's clinical record revealed the following:</p> <ul style="list-style-type: none"> - Absence of grievances or complaints 2/17/15 - 4/23/15. - Lack of evidence that R1 was referred to or seen by PT from 3/13/15 - 5/1/15. - On 5/1/15, a formal complaint was submitted by S6 and R1 was seen by PT that day at which time it was determined that his self-transfers were not safe. - From 4/7/15 - 4/15/15, the facility failed to provide R1's leg wrap treatment for a total of 18 times. - A new order for the leg wrap was written by S1 on 4/15/15. - During the interview with R1 and S6, R1 stated that he recorded a conversation with E1 (NHA) on 4/30/15 at 11:49 AM. The surveyors listened to the recording, which revealed that R1 told E1 that he was having confrontations and felt this was a "hostile environment" with E5 and requested to be moved. E1 stated that he did not wish to be recorded but understood that R1 wanted some "memorial of the discussion". R1 stated, "I just want to make sure we are all on the same page. That we all understand each other and there is no misinterpretation and I think a recording does that perfectly." 	F 223		

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F 223	<p>Continued From page 7</p> <p>5/6/15 at 1:00 PM - The surveyors interviewed E15 (LPN), who stated he was the assigned floor nurse for R1 on 4/30/15 day shift. E15 stated he saw E5 in R1's room on 4/30/15 "as she starts treatments early after report". E15 counted his medications and then walked the hallway to check on his residents. As he was returning up the hallway, R1 was calling out E16's (another LPN) name. E15 walked into the room after hearing R1 call out. R1 was on his personal cell phone with 911, an outside emergency help line. R1 stated to E15 that 911 dispatch was on the phone and handed it to E15. E15 stated that R1 was flustered and told him he did not want E5 wrapping his leg. Despite R1 telling E5 on 4/27/15 that he did not want her in his room or to wrap his leg, E5 was seen in R1's room on 4/30/15, as witnessed by E15, and R1 felt that he needed to call 911 and did so.</p> <p>5/8/15 at 7:17 AM - The surveyors interviewed E5, who stated that she was the unit manager and in charge, and she also provided wound care treatments for her unit. The following issues were discussed with E5:</p> <ul style="list-style-type: none"> - E5 stated that many times when she entered R1's room at 7:10 - 7:15 AM, he was already dressed. - When asked if R1 requested to speak to PT, E5 stated if he asked for it, it would have happened. - E5 stated that she went into R1's room on Monday (4/27/15) because staff reported he was refusing to transfer without a lift. E5 stated that R1 did not want her in there. E5 stated that she offered to manually transfer him with 4 staff people, and R1 refused. E5 stated R1 was being 	F 223	

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F 223	Continued From page 8 mean to her, yelling at her and telling her she was not following doctor's orders, which E5 said was a lie. E5 stated that R1 told her he could not tolerate weight bearing for transfers. When asked by this surveyor why the facility's in house PT was not consulted about R1's transfer status using the facility's Rehabilitation Referral form, E5 stated "Honestly, they (nursing) are not used to doing this if there is not a payer source. It all comes down to the non-payer source. They are not refusing care ... nursing can do therapy." E5 stated it was brought up in the leadership meeting on Monday (4/27/15). E5 stated it was recommended to her not to use a Hoyer lift. When asked who told her that, E5 stated no one was making the decisions, but the CNA's were uncomfortable with using the lift. E5 also stated she did not think it was safe to use a Hoyer lift, and it was her opinion, R1 would have done something to make himself fall out of it. E5 stated that nothing was mentioned by R1 until Monday (4/27/15) and he should have already been discharged. E5 stated they could pivot R1 and asked why they would need therapy for that. E5 stated he was demanding a Hoyer (lift) only ... "you just don't demand things". E5 stated that in the leadership meeting on 4/27/15, E1 asked her to get a script from S2 (foot doctor) that he can weight bear since R1 was asking for a Hoyer lift. E5 stated they were trying to figure out what to do with R1 as he was a very difficult patient. E5 stated at first that E8 (facility's doctor) asked her, but then changed and stated E1 and E2 (DON) asked her to see about getting a script from S2 to say he was cleared to be discharged. E5 stated that S2 would have to say from a podiatry point of view was yes, R1 was able to go home with home health care. E5 stated that she asked S2 to do it, but he did not have to write it. R1's clinical record	F 223		

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F 223	<p>Continued From page 9</p> <p>revealed a 4/28/15 script faxed from S2, which stated "weight bearing as tolerated for physical therapy". In addition, S2 refused to write that R1 was cleared to be discharged from the facility.</p> <p>- When asked what was the facility's response when R1 became non-weight bearing, E5 stated, "You mean he was never picked up from PT from March to April? That's terrible ... can't believe PT is not involved." E5 was shown that there were 2 consultations written that never reached PT, E5 stated that was their fault. E5 stated there was a lot of breakdown in communication.</p> <p>- E5 stated she was interested in when R1 went from "skilled to pink". When asked what she meant, E5 explained that there was a color label on the outside of the resident's chart to indicate if there was a payer source or not. E5 stated green was managed care, yellow was Medicaid, blue was Medicare, white was private pay and pink was no payer source. E5 stated when R1's 30 days were exhausted (occurred mid-March) and he did not leave the facility, that's when E1 made him a non-payer source. E5 stated that when the nurses see a pink label, they feel they should not have to document since it's not a blue label. When asked if that meant he stopped getting care, E5 stated they never stopped giving care, he refused care, i.e. refused to get out of bed and go to the dining room. E5 stated remember on 4/7, R1 had no payer source and asked how PT can see him if there is no payer source. She felt the facility was going over their boundaries with having no payment for services. When asked about S2's (foot doctor) orders for PT, E5 stated that the consultation report was not an order. It was a recommendation until E8 (facility's doctor) approved it. E5 asked this surveyor if S2 knew he</p>	F 223		

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F 223	<p>Continued From page 10</p> <p>had no payer source. This surveyor replied that S2 was under the impression that R1 was receiving PT here at the facility per his orders. E5 stated he was getting nursing care, but would not be entitled to physical therapy since the facility was not being paid. E5 stated it was a major issue.</p> <p>- E5 stated that R1 told her he did not want her wrapping his leg anymore on Monday, 4/27/15. E5 stated "once he tells me I'm not allowed to change his ace, I'm not allowed to go in there anymore ... it was assigned to someone every day." When asked about R1's leg treatment, E5 stated that there should be a stop order until the patient was seen again by the doctor and had a new order to resume. E5 stated that R1 was very insulted when she asked R1 to ask S1 (wound care doctor) how he wanted the ace wrap to continue. E5 stated that she asked if they could discontinue it and R1 was very mad and said I have to have this (wrap). E5 stated that S1 wrote a lifetime order for R1's ace wrap and she did not understand why. When E5 was shown the April 2015 TAR and asked who signed R1's treatments off from 4/27/15 through 4/30/15, E5 confirmed she signed the TAR everyday and explained that the staff was bad about signing off and she checked them at the end of the day and filled in whatever was blank when she knew it was done.</p> <p>- When first asked about being in R1's room on 4/30/15, E5 denied being in the room. When asked again she said she did not recall being in R1's room. E5 denied having said to R1 that she would do the ace wrap or no one would do it. E5 stated it was all about the Hoyer lift.</p> <p>- When asked about refusing to give R1 her last</p>	F 223		
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F 223	<p>Continued From page 11</p> <p>name, E5 confirmed that she did not give her last name because he was being very ugly. E5 stated it was on her badge and in front of him. E5 stated if he could not see, he would not be on his cell phone or computer all day.</p> <p>- When asked if her interactions with R1 were ever heated, E5 stated no, but that she talks loud. She would never do that to him. When asked if R1 ever yelled at her, E5 stated yes. E5 stated that R1 would never admit to it, but he did.</p> <p>- When asked why did R1's situation rise to a point of the 911 call the morning of 4/30/15 if R1's issue of transferring was discussed frequently among the facility staff, E5 stated R1 needed to be out since his insurance ended and she did not understand why he wanted to stay, knowing that he could not pay.</p> <p>5/8/15 at approximately 12:10 PM - This surveyor observed a pink label on the outside of R1's chart, confirming E5's statement above.</p> <p>The facility failed to protect R1's right to be free from abuse when R1 felt threatened and intimidated by a staff person in a supervisory role and deprived of goods and services when his requests for physical therapy, transfer assistance and a different staff person to wrap his leg were disregarded. Findings were reviewed at the exit conference on 6/4/15 at 5:30 PM with E1 and E2.</p>	F 223		
F 224 SS=D	<p>483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATE</p> <p>The facility must develop and implement written policies and procedures that prohibit</p>	F 224		

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F 224	<p>Continued From page 12</p> <p>mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Cross refer to F309, examples 1a and 1b.</p> <p>Based on record review, interviews and review of facility documentation, it was determined that for one (R1) out of 3 sampled residents, the facility failed to protect R1's right to be free from neglect when physician orders from two consultations on 4/6/15 and 4/20/15 were not followed and physical therapy was not provided. In addition, R1's physician order from S1 (wound care doctor) was not followed and treatment was not provided from 4/7/15 through 4/15/15 to wrap his left leg twice a day, a total of 18 opportunities. Findings include:</p> <p>The facility policy entitled "Abuse Prohibition", last revised on 12/1/11, stated, "... Neglect is defined as: ... Failure to carryout a prescribed treatment plan for a patient ...".</p> <p>1a. Undated - S2's (foot doctor) consultation report stated, "... Ok for PT, WB as tolerated ...". This consultation report was reviewed and acknowledged by EB (facility's doctor) on 4/7.</p> <p>4/20/15 - S2's consultation report stated, "... Start PT to (increase) strength L leg ... Ok for limited WB while in PT setting c supervision ...". This consultation report was reviewed and acknowledged by E7 (NP) on 4/20.</p>	F 224	<p>F-224</p> <p>A- R1 was plcked up on rehabilitation caseload 5/6/2015 and wraps were re-instituted 4/15/2015. No adverse reaction occurred as a result of discontinuation of wraps from 4/7-4/15/2015.</p> <p>B- Whole house current resident chart review by nurse management team/designee will be completed on or before 7/31/2015 to assure all consults and orders were transcribed correctly.</p> <p>C- 1) DON/designee will educate all licensed staff and rehab on new communication process. "Refer to plan of correction F223 C-5" 2) DON/designee will educate all licensed staff on the proper procedure to discontinue or clarify orders. "Refer to plan of correction F223 C-6"</p> <p>D- DON/designee Monitor a sample of 5% of resident charts daily until consistently reach 100% compliance over 3 daily consecutive evaluations. Then monitor 5% of resident charts weekly until consistently reaching 100% success for 3 evaluations, then monitor monthly until consistently reaching 100% success over 3 consecutive evaluations. If 100% is reached, conclude that successful achievement of problem has been addressed. Review at quarterly quality assurance meeting.</p>	07/31/2015	

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F 224	<p>Continued From page 13</p> <p>5/5/15 at 3:10 PM - In an interview, E9 (PT Director) stated that he was not notified by nursing of the 4/6/15 and 4/20/15 physician orders for PT from S2. E9 stated the last time he saw R1 on a clinical basis was 3/13/15.</p> <p>5/6/15 at 7:53 AM - In an interview, E7 stated that consultation reports are orders from other doctors and they are to be followed and implemented. E7 expected that R1's order was being followed and that R1 was receiving PT.</p> <p>5/6/15 at 10:50 AM - In an interview, E14 (RN) stated that she received S2's consultation report from 4/6/15 and transcribed it to a physician's order and the TAR. E14 stated that she thought R1 was on PT's caseload and admitted that she did not notify PT of the new order.</p> <p>The facility failed to provide physical therapy as prescribed twice by S2 on 4/6/15 and 4/20/15. Findings were reviewed during the exit conference on 6/4/15 at 5:30 PM with E1 (NHA) and E2 (DON).</p> <p>1b. 3/25/15 - R1 was seen by S1 for a left ankle wound. S1's consultation report stated, "... continue ... wrap and Bactroban BID (twice a day)."</p> <p>4/7/15 - A physician's verbal order from E8 stated to discontinue Bactroban as the left ankle wound had healed.</p> <p>Review of R1's April 2015 TAR revealed the absence of R1's treatment for a wrap BID was provided from 4/7/15 through 4/15/15, a total of 18 scheduled times. The April 2015 TAR revealed</p>	F 224		

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F 224	<p>Continued From page 14</p> <p>that when the Bactroban wound treatment was discontinued on 4/7/15 so was R1's prescribed wrap twice a day.</p> <p>4/15/15 - S1's consultation report stated, "... 1) Will need ... wrap every day. Off at bedtime ... Will need this dressing regimen for lifetime ... compression wrap used to treat swelling. Essential to prevent further wounds ...".</p> <p>4/30/15 - In an interview at 6:45 PM, S6 (family member) stated that E5 (RN) told her S1's order expired and E5 was not going to wrap R1's left leg. S6 stated that she told E5 that R1 had an order to wrap his left leg twice a day. S6 stated that she had to take R1 to another consult with S1 on 4/15/15 in order to obtain a lifetime order for a compression wrap.</p> <p>The facility failed to follow S1's physician orders for a compression wrap from 4/7/15 through 4/15/15, a total of 18 scheduled times. Findings were reviewed with E1 and E2 on 6/4/15 at 5:30 PM.</p>	F 224		
F 280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility</p>	F 280	<p>F 280</p> <p>A- R1 has been discharged to home from the facility. R1's care plan was reviewed and updated to reflect current weight-bearing transfer status before discharge occurred.</p> <p>B- DON/designee will audit all resident care plans for weight bearing and transfer status by 7/31/15 to ensure accurate documentation.</p> <p>C- DON/designee will educate by 7/31/15 all licensed nurses regarding revision/review of ADL care plans. Unit Managers will revise/review as necessary to assure accuracy. Unit manager will bring all consults and orders to morning meeting to discuss and ensure careplans have been revised appropriately.</p> <p>D- DON/designee Monitor a sample of 5% of resident charts daily until consistently reach 100% compliance over 3 daily consecutive evaluations. Then monitor 5% of resident charts weekly until consistently reaching 100% success for 3 evaluations, then monitor monthly until consistently reaching 100% success over 3 consecutive evaluations. If 100% is reached, conclude that successful achievement of problem has been addressed. Review at quarterly quality assurance meeting</p>	07/31/2015

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F 280	Continued From page 15 for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Cross refer to F309, example 1a. Based on record review, interview and review of facility documentation, it was determined that for one (R1) out of 3 sampled residents, the facility failed to review and revise R1's ADL care plan since 2/18/15 even after he experienced changes in transfer status. Findings include: The facility policy entitled "Care Plans", last revised on 1/2/14, stated, "... The comprehensive care plan is ... 2.4 Reviewed and revised ... as needed to reflect response to care and changing needs and goals ...". 2/18/15 - R1 was care planned for "... exhibits or ... at risk for decreasing ability to perform ADL ... due to left leg cellulitis, deconditioning ...". An intervention included: "... Provide extensive assistance ... transfers ...". After 2/18/15, R1's transfer status changed four (4) times, i.e. extensive assist, limited assist, independent and non-weight bearing (total assist). Review of R1's clinical record revealed this care plan remained in place as of 5/1/15, approximately 2 1/2 months later, even when R1's weight bearing status	F 280			

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F 280	Continued From page 16 affecting transfers changed.	F 280		
F 309 SS=G	<p>5/5/15 - In an interview at 11:12 AM, E4 (CRC) confirmed that R1's ADL care plan was not reviewed and revised. The facility failed to review and revise R1's ADL care plan to reflect changes in transfer status. Findings were reviewed with E1 (NHA) and E2 (DON) on 6/4/15 at 5:30 PM.</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, interviews and review of facility documentation, it was determined that for one (R1) out of 3 sampled residents, the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical well-being, in accordance with the plan of care. The facility failed to re-assess R1 after he became non-weight bearing on 3/18/15; failed to communicate with PT and implement the 4/6/15 physician's order for PT; failed to transcribe, communicate and implement the 4/20/15 physician's order for PT; and failed to provide physical therapy as ordered from 4/6/15 to 5/1/15, a total of 25 days. As a result, the 5/1/15 PT evaluation noted a decline in R1's LE strength,</p>	F 309	<p>F 309</p> <p>A- R1 was picked up on rehabilitation caseload 5/6/2015 and wraps were re-Instituted 4/15/2015, No adverse reaction occurred as a result of discontinuation of wraps from 4/7-4/15/2015.</p> <p>B- Whole house current resident chart review by nurse management team/designee will be completed on or before 7/31/2015 to assure all consults and orders were transcribed correctly.</p> <p>C- 1) DON/designee will educate all licensed staff and mid-level providers on the procedure to clarify and implement consult recommendations. Consults will be clarified and implemented after physician/ extender review. All consults and orders will be brought to morning meeting to ensure disciplines are notified after physician/extender review</p> <p>2) DON/designee will educate all licensed staff and rehab on new communication process. "Refer to plan of correction F223 C-5"</p> <p>3) DON/designee will educate all licensed nursing staff on proper follow-up documentation with treatment completion. "Refer to plan of correction F223 C-4"</p>	07/31/2015

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F 309	<p>Continued From page 17</p> <p>poor standing balance, impaired transfers and pain on L foot upon weight bearing in contrast to his last PT evaluation on 3/13/15 where he was independent on transfers. In addition, R1's physician orders for wound care on 4/1/15 were not followed and provided from 4/7/15 through 4/15/15, a total of 18 scheduled times. Findings include:</p> <p>The facility's policy entitled "Transcription of Orders", last revised on 10/1/12, stated, "Orders from an authorized licensed independent practitioner (doctor) are transcribed by a licensed nurse ... Purpose: To communicate all practitioners orders to caregivers regarding patient's care and treatment."</p> <p>1a. R1 was admitted to the facility on 2/17/15 for short-term rehabilitation post hospitalization for cellulitis on the left lower leg and a wound on the anterior aspect of the left ankle. Diagnoses included BKA on right leg, hypertension, diabetes and peripheral neuropathy.</p> <p>2/17/15 - The Interagency Nursing Communication Record from the hospital stated that R1 was to weight bear to left foot with surgical shoe for transfers only.</p> <p>2/18/15 - R1 was care planned for "... exhibits or ... at risk for decreasing ability to perform ADL ... due to left leg cellulitis, deconditioning ...". An intervention included: "... Provide extensive assistance ... transfers ...". Review of R1's clinical record revealed this care plan remained in place as of 5/1/15, approximately 2 1/2 months later.</p> <p>2/18/15 - A physician's order stated that Occupational Therapy would evaluate and treat</p>	F 309	F 309 (cont) D- DON/designee Monitor a sample of 5% of resident charts daily until consistently reach 100% compliance over 3 daily consecutive evaluations. Then monitor 5% of resident charts weekly until consistently reaching 100% success for 3 evaluations, then monitor monthly until consistently reaching 100% success over 3 consecutive evaluations. If 100% is reached, conclude that successful achievement of problem has been addressed. Review at quarterly quality assurance meeting.		

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F 309	<p>Continued From page 18 5-6 times a week x 30 days.</p> <p>2/18/15 - The Occupational Therapy Initial Evaluation stated, "Patient referred to skilled OT due to new onset of impaired ADL performance, impaired balance, impaired functional activity tolerance, impaired functional mobility ... impaired strength and impaired transfers indicating the need for OT to increase I w/ADLs, facilitate dynamic standing balance, increase functional activity tolerance, increase safety awareness and facilitate sitting tolerance and postural control."</p> <p>2/19/15 - A physician's order stated that Physical Therapy would evaluate and treat 6 times a week for 30 days.</p> <p>2/19/15 - The Physical Therapy Initial Evaluation stated that R1's impairments were decreased lower extremity strength, impaired transfers and no ambulation secondary to precautions. The summary of findings stated, "... Based on his diagnosis, pt weight-bearing is limited to transfers only. While this will decrease time for wound healing, pt is unable to ambulate at this time. Mild LE weakness was discovered, which will only by (sic) augmented by the increased amount of time pt will be required to spend sedentary secondary to his WBing precautions."</p> <p>2/20/15 - The physician's admission history and physical stated that R1 was alert and oriented, had decreased vision, ambulatory dysfunction, decreased lower extremity sensation, left lower leg edema, severe stasis and a left lower extremity wound. The physician's plan was to continue with administration of two antibiotics for the left foot wound, local wound care treatment in addition to physical therapy and occupational</p>	F 309			

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F 309	<p>Continued From page 19</p> <p>therapy evaluation and treatment for ambulatory and ADL dysfunction.</p> <p>2/24/15 - The MDS assessment documented that R1 was able to make his own decisions and required limited assist of one staff person for transfers. This assessment was in contrast to the 2/18/15 care plan which required extensive assistance.</p> <p>2/25/15 - E8's (facility's doctor) progress note stated, "... L (left) foot ulcer (decreased) swelling & pain L foot edema (decreased) ... (decreased) LE sensation ... L foot cellulitis - Cipro + Augmentin (antibiotics) ... P. (peripheral) neuropathy - fairly advanced ... amb/ADL dys (dysfunction) - cont. (continue) PT/OT."</p> <p>3/13/15 - The Physical Therapy Discharge Summary stated all goals were met and under the summary of progress, "Pt currently I (independent) with all transfers and I with HEP for continued strengthening in order to prepare for gait activities once WBing precautions on LLE are lifted."</p> <p>3/13/15 - The Occupational Therapy Discharge Summary stated all goals were met.</p> <p>3/18/15 and timed 9:09 AM - E7's (NP) progress note stated, "... edema LLE ... left foot wound slowly healing ... amb dys wgt bearing for transfers bed to wc, independent with ADL ... no c/o pain ...".</p> <p>3/18/15 - R1 was seen by S1 (wound care doctor). The consultation report, mistakenly dated 3/16/15, stated "... Non weight bearing ...". The consultation report was reviewed and</p>	F 309		

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F 309	Continued From page 20 acknowledged by E7's initials and dated 3/19. 3/18/15 and timed 8:00 PM - A physician's order was transcribed and stated, "D/C (discontinue) WB to L foot c surgical shoe transfers. Pt is NWB LLE." It is unclear from the clinical record as to why this order was never signed by the facility's doctor and how the facility responded when R1's status changed to non-weight bearing. The clinical record lacked evidence that R1 was re-assessed when he became non-weight bearing. 3/25/15 - S1's consultation report stated, "... (2) no ambulation ...". Undated - S2's (foot doctor) consultation report stated, "... Ok for PT, WB as tolerated ...". This consultation report was reviewed and acknowledged by E8 on 4/7. 4/6/15 and timed 10:35 PM - The undated S2's consultation report was transcribed to a physician's order, however, this order was never received by PT. The facility failed to provide PT despite a consulting physician's order to do so. 4/20/15 - S2's consultation report stated, "Wound looks healed - Start PT to (increase) strength L leg ... - C/W (continue with) transfer - Ok for limited WB while in PT setting c supervision ...". This consultation report was reviewed and acknowledged by E7 on 4/20. It is unclear in the clinical record why the above orders were never transcribed as a physician's order and implemented. S2's second order to start physical therapy was never received by PT. The facility failed to provide PT despite a consulting physician's order to do so.	F 309			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085025	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/04/2015
NAME OF PROVIDER OR SUPPLIER CHURCHMAN VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 4949 OGLETOWN-STANTON ROAD NEWARK, DE 19713	
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F 309	<p>Continued From page 21</p> <p>4/20/15 - E7's progress note stated, "... seen by S2, wound looks healed ... edema LLE ... ok for limited WB ... keep LLE elevated ...".</p> <p>4/28/15 - Record review revealed a faxed copy of a prescription addressed to E5 (UM, RN) from S2 which stated, "patient is weight bearing (sic) as tolerated for PT". The facility failed to provide PT despite a consulting physician's order to do so.</p> <p>4/30/15 - Record review revealed a faxed copy of a prescription addressed to E12 (facility's unit clerk) from S3 (foot doctor's staff) which stated, "Pt cleared to WB L leg".</p> <p>4/30/15 and timed 2:00 PM - E12's typed statement in R1's clinical record stated, "Received call back from S3 ... S3 stated, 'He (S2) would not write a rx (prescription) for R1 to be discharged. That is our Medical Director's decision. He has already written a rx for full weight bearing.' E12 verbalized understanding of (S2's) decision & reiterated that R1 insisted this rx come directly from (S2) ...".</p> <p>4/30/15 - A physician's order stated that R1 was to bear full weight on LLE.</p> <p>4/30/15 - E8's progress note stated, "c/o (complaint of) L LE pain - asking staff to Hoyer lift him - called police to complain ... L good pedal pulse ... no edema L foot ... skin intact ... hoyer lift is inappropriate - D/W patient. L LE wound has healed. He has good pulses. There is no reason why he can't bear full weight on L LE. D/W ... podiatry & he agrees c my assessment. Full weight bearing ordered. D/W staff. Pt needs to go home! Medically stable for D/C (discharge)." R1</p>	F 309		

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F 309	<p>Continued From page 22</p> <p>was not discharged. E8 ordered full weight bearing despite the fact that R1 had been non-weight bearing since 3/18/15 and despite the fact that R1 had not received PT for weight bearing as ordered twice by a consulting physician.</p> <p>5/1/15 - Two physician's orders stated that OT and PT were to evaluate and treat R1.</p> <p>5/1/15 and timed 2:10 PM - An observation was made of PT and OT assessing R1's range of motion, strength and transfers. R1 demonstrated how he was transferring himself from the bed to the wheelchair and vice versa. E9 (PT Director) stated, "This is different (referring to transfers) than when we evaluated you before." E9 and E10 (OT) stated that R1 was a good candidate for using a sliding board when transferring as they both agreed his self-transfer status was not safe.</p> <p>5/1/15 and timed 4:16 PM - The Occupational Therapy Initial Evaluation stated, "... Patient referred to skilled OT due to impaired ADL performance, impaired functional mobility and impaired transfers ... Pt previously on OT caseload from 2/18/15 to 3/13/15. Pt was d/c secondary to all goals met and was issued theraband UE HEP. Pt reports 'probably not as much as I should have' in re: to whether he has been completing HEP ... Pt unsafe during transfer. Pt does not WB through LLE ... PLOF = independent (at previous OT d/c) ... Pt reports pain 4/10 when he weight bears on L foot, 0/10 at rest ... Pt presents with decline in safety during transfers, slight decline in functional transfers, limited standing tolerance requiring skilled OT services to address. Recommend OT 3x/week in conjunction with UE HEP in order to increase l</p>	F 309		

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F 309	<p>Continued From page 23</p> <p>with toileting and functional transfers and to increase safety during transfers. Recommend OT cotreat with physical therapy for safety during transfers."</p> <p>5/1/15 and timed 4:41 PM - The Physical Therapy Initial Evaluation stated, R1's impairments were "pain on L foot upon wt bearing, poor safety awareness during transfers and poor standing balance". The clinical impressions were "Pt is noted with pain and muscle weakness on L foot upon wt bearing resulting to poor standing balance and increasing risk for falls ... Pt will benefit from skilled PT services to increase LE strength, improve balance, and complete transfers safely in order to decrease risk for falls, and allow patient to return home at highest functional level." The reason for the referral stated, "Patient demonstrates new onset of impaired transfers and pain indicating the need for PT to increase strength, promote safety awareness and reduce risk for falls ... Pt was previously on PT/OT caseload and was d/c secondary to meeting all goals. Pt is re-evaluated for PT/OT and services per consult with E1 (NHA) and E2 (DON)." This re-evaluation occurred after a meeting with DLTCRP.</p> <p>As noted by OT and PT on 3/13/15, "Pt. was d/c secondary to all goals met ..." and "... all goals were met ... Pt currently I with all transfers ...". On 5/1/15, however, OT and PT noted, "Pt unsafe during transfer. Pt does not WB through LLE ... Pt presents with decline in safety during transfers, slight decline in Functional transfers ..." and "... poor safety awareness during transfers and poor standing balance ... increasing risk for falls ... new onset of impaired transfers and pain ...".</p>	F 309			

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F 309	Continued From page 24 5/5/15 at 3:10 PM - In an interview, E9 stated that he was not notified by nursing of the 4/6/15 and 4/20/15 physician orders for PT from S2. E9 stated the last time he saw R1 on a clinical basis was 3/13/15 and he was independent with transfers. 5/6/15 at 7:53 AM - In an interview, E7 stated that consultation reports are orders from other doctors and they are to be followed and implemented. E7 expected that R1's order was being followed and that R1 was receiving PT. 5/6/15 at 9:50 AM - In an interview, E13 (LPN) stated that she did not write the 3/18/15 physician's order for non-weight bearing LLE, however she signed the order at 8:00 PM and transcribed it to the TAR. E13 stated that the Physical Therapy department was closed at that time and she slid it under PT's door. E13 then stated that she placed the original physician's order and S1's consultation report in the facility's doctor folder to be signed. E13 also stated that she passed on R1's non-weight bearing status in report to the next shift. 5/6/15 at 10:50 AM - In an interview, E14 (RN) stated that she received S2's 4/6/15 consultation report that stated ok for physical therapy, weight bearing as tolerated and transcribed it to a physician's order and the TAR. E14 stated that she thought R1 was on PT's caseload and admitted that she did not notify PT of the new order. E14 stated that she placed the physician's order and S2's 4/6/15 consultation report in the facility's physician folder to be signed. E14 stated that she passed on R1's new orders to the next shift.	F 309			

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F 309	<p>Continued From page 25</p> <p>5/6/15 at 12:03 PM - In an interview, R1 stated that he gave S2's 4/20/15 consultation report to E5 as he returned to the facility during day shift.</p> <p>5/6/15 at 2:51 PM - In an interview, E11 (PT) stated that she was covering the PT department when E9 (PT Director) was on vacation from 4/23/15 through 4/28/15. When asked if anyone on staff approached you from 4/23/15 through 4/28/15 about R1 asking to talk to E9 about transfer status and restarting PT, E11 stated "no".</p> <p>5/7/15 at 3:04 PM - In a telephone interview, S3 stated that this office received multiple calls from the facility's staff inquiring about scripts for R1's weight bearing status and discharge. S3 stated "We were under the impression that he had been there doing the physical therapy."</p> <p>5/8/15 at 7:17 AM - In an interview, E5 stated that the consultation reports are not actual orders and they have to call E8 to get her approval before they follow the consultant's recommendations.</p> <p>The facility failed to re-assess R1 when he became non-weight bearing on 3/18/15; failed to communicate with PT and implement the 4/6/15 physician's order for PT; failed to transcribe, communicate and implement the 4/20/15 physician's order for PT; and failed to provide physical therapy as ordered from 4/6/15 to 5/1/15, a total of 25 days. As a result, the 5/1/15 PT evaluation noted a decline in R1's LE strength, poor standing balance, impaired transfers and pain on L foot upon weight bearing in contrast to his last PT evaluation on 3/13/15 where he was independent on transfers. Findings were reviewed during the exit conference on 6/4/15 at 5:30 PM with E1 and E2.</p>	F 309		
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F 309	<p>Continued From page 26</p> <p>1b. 3/25/15 - R1 was seen by S1 for a left ankle wound. S1's consultation report stated, "... continue ... wrap and Bactroban BID (twice a day)."</p> <p>4/1/15 - S1's consultation report stated, "moisturize & wrap BID. Make sure wrap is applied correctly. Rectagles (sic) become square and should be seen all the way down". It is unclear in R1's clinical record as to why S1's order was not transcribed onto a physician's order sheet and the April 2015 TAR updated.</p> <p>4/7/15 - A physician's verbal order from E8 stated to discontinue Bactroban as the left ankle wound had healed.</p> <p>Review of R1's April 2015 TAR revealed that R1's treatment for a wrap BID was not provided for a total of 18 times from 4/7/15 through 4/15/15. The April 2015 TAR revealed that when the Bactroban wound treatment was discontinued on 4/7/15 so was R1's prescribed wrap twice a day.</p> <p>4/15/15 - S1's consultation report stated, "... 1) Will need ... wrap every day. Off at bedtime ... Will need this dressing regimen for lifetime ... compression wrap used to treat swelling. Essential to prevent further wounds ...".</p> <p>4/30/15 - In an interview at 6:45 PM, S6 (POA) stated that E5 told her S1's order expired and E5 was not going to wrap R1's left leg. S6 stated that she told E5 that R1 had an order to wrap his left leg twice a day. S6 stated that she had to take R1 to another consult with S1 on 4/15/15 in order to obtain a lifetime order for a compression wrap.</p>	F 309		
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F 309	Continued From page 27 The facility failed to follow S1's physician orders for a compression wrap from 4/7/15 through 4/15/15, a total of 18 scheduled times. Findings were reviewed with E1 and E2 on 6/4/15 at 5:30 PM.	F 309		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of facility documentation, it was determined that for one (R1) out of 3 sampled residents, the facility failed to maintain R1's clinical record in accordance with accepted professional standards and practices that are complete and accurately documented. Findings include: The facility policy entitled, "Nursing Documentation", last revised on 10/1/12, stated, "... Documentation for subsequent and/or routine care and procedures may be completed by ... the use of a checklist, flow charts, or other	F 514	F 514 A- R1 has been discharged to home from the facility. B- A whole house review of current treatment records will be completed by the nurse management team on or before 7/31/15 to identify lack of initials and accurate accounting for treatments. C- 1) DON/designee will educate all licensed nursing staff on proper follow-up documentation of treatment completion. ADON/designee to conduct random reviews of TAR's daily to ensure proper staff sign off of care provided. 2) DON/designee will educate all licensed nursing staff on proper follow-up documentation with treatment completion. Unit Managers/designee will review treatment/mar records daily for omission of initials and follow-up with nurses as necessary. "Refer to plan of correction F223 C-4" 3) DON/designee will educate all licensed staff and rehab on new communication process. "Refer to plan of correction F223 C-5" D- DON/designee Monitor a sample of 5% of resident charts daily until consistently reach 100% compliance over 3 daily consecutive evaluations. Then monitor 5% of resident charts weekly until consistently reaching 100% success for 3 evaluations, then monitor monthly until consistently reaching 100% success over 3 consecutive evaluations. If 100% is reached, conclude that successful achievement of problem has been addressed. Review at quarterly quality assurance meeting	07/31/2015

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F 514	<p>Continued From page 28</p> <p>documentation tools ... Purpose: ... provide accurate accounting of care and monitoring provided ... Nurses will not: 1.1 Document services that were not performed; 1.2 Document services before they are performed ...".</p> <p>1. In an interview on 5/8/15 at approximately 10:00 AM, E5 (UM, RN) admitted to signing off R1's leg wrap treatment on the April 2015 TAR from 4/27/15 through 4/30/15 when she did not perform the treatments.</p> <p>2a. R1's TAR revealed that he was ordered to receive treatment to his left ankle twice a day. Review of R1's TARs revealed the following incomplete documentation: - March 2015 - ten (10) out of 54 scheduled opportunities lacked documentation; - April 2015 - four (4) out of 12 scheduled opportunities lacked documentation.</p> <p>2b. Review of R1's April 2015 TAR revealed that he was ordered to have an ace wrap removed at night. Six (6) out of 16 scheduled opportunities lacked documentation to indicate completion of this task.</p> <p>3. The facility's policy entitled "Transcription of Orders", last revised on 10/1/12, stated, "Orders from an authorized licensed independent practitioner (doctor) are transcribed by a licensed nurse ... Purpose: To communicate all practitioners orders to caregivers regarding patient's care and treatment."</p> <p>Review of R1's clinical record revealed that a 4/20/15 consultation report from S2 (foot doctor) with orders for the following were not transcribed onto a physician's order sheet:</p>	F 514		
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NAME OF PROVIDER OR SUPPLIER CHURCHMAN VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 4949 OGLETOWN-STANTON ROAD NEWARK, DE 19713
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F 514	<p>Continued From page 29</p> <ul style="list-style-type: none"> - Start PT to increase strength left leg; - Continue with transfer; - Ok for limited WB while in PT setting with supervision; and - No left leg dependency over 15 minutes. <p>The facility failed to maintain a clinical record for R1 that was complete and accurately documented. Findings were reviewed during the exit conference on 6/4/15 at 5:30 PM with E1 (NHA) and E2 (DON).</p>	F 514		
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DELAWARE HEALTH AND SOCIAL SERVICES

Division of Long Term Care
Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Churchman Village

DATE SURVEY COMPLETED: June 4, 2015

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
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	<p>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</p> <p>An unannounced complaint survey was conducted at this facility from April 30, 2015 through June 4, 2015. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 90. The survey sample size was three (3).</p> <p>Abbreviations/definitions used in this report are as follows:</p> <p>NHA - Nursing Home Administrator; DON - Director of Nursing; NP - Nurse Practitioner; CRC - Clinical Resource Coordinator; UM - Unit Manager; RN - Registered Nurse; LPN - Licensed Practical Nurse; CNA - Certified Nurse's Aide;</p> <p>ADL - Activities of Daily Living, tasks needed for daily living such as dressing, toileting, bathing and eating; amb - ambulatory, walking; anterior - front; augmented - increased; BID - twice a day; BKA - below the knee amputation; Bactroban - topical ointment for wounds; c - with; c/o - complaint of;</p>	<p>Please refer to CMS 2567 survey report dated 06/04/2015.</p> <p>Substantial compliance on or before 07/31/2015</p>	
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Provider's Signature

Title

ADMINISTRATOR

Date

7/1/2015



**DELAWARE HEALTH
AND SOCIAL SERVICES**

Division of Long Term Care
Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Churchman Village

DATE SURVEY COMPLETED: June 4, 2015

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
3201	<p>cellulitis - inflammation of the tissues indicating a local infection; d/c - discharged; D/W - discussed with; DLTCRP - Division of Long Term Care Residents Protection, state regulatory agency; dys - dysfunction; Diabetes - disease where blood sugar levels are high; HEP - Home Exercise Program; Hoyer lift - total mechanical lift; Hypertension - high blood pressure; I - independent; i.e. - such as; lbs - weight in pounds; L - left; LE - lower extremity; LLE - left lower extremity; MDS - Minimum Data Set, standardized assessment form used in nursing homes; NWB - non-weight bearing; OT - Occupational Therapy; PLOF - Prior Level of Functioning; pt - patient; PT - Physical Therapy; peripheral neuropathy - disease affecting nerves often causing weakness, numbness and pain in the hands and feet; re - regarding; rx - prescription; sedentary - inactive; stasis - decreased blood circulation TAR - Treatment Administration Record; theraband - resistance exercise tool to increase strength; UE - upper extremity; w/ - with; WB or WBing - weight bearing; wc - wheelchair; wt or wgt - weight</p> <p>Regulations for Skilled and Intermediate Care Facilities</p>		

Provider's Signature _____ Title _____ Date _____



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3201.1.0	Scope		
3201.1.2	<p>Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.</p> <p>This requirement is not met as evidenced by:</p> <p>F207 §483.12(c) Equal Practices Regardless of Payment Source</p> <p>§483.12(c)(1) A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all individuals regardless of source of payment.</p> <p>This requirement was not met as evidenced by:</p> <p>Based on observation, record review and interviews, it was determined that for one (R1) out of 3 sampled residents, the facility failed to ensure that R1 was not treated</p>		

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	<p>based on his source of payment when providing services. Findings include:</p> <p>In an interview on 5/8/15 at 7:17 AM, E5 (UM, RN) stated that she was interested in when R1 went from "skilled to pink". When asked what she meant, E5 explained that there was a color label on the outside of the resident's chart to indicate if there was a payer source or not. E5 stated green was managed care, yellow was Medicaid, blue was Medicare, white was private pay and pink was no payer source. E5 stated when R1's 30 days were exhausted (occurred mid-March) and he did not leave the facility, that's when E1 (NHA) made him a non-payer source. E5 stated that when the nurses see a pink label, they feel they should not have to document since it's not a blue label. When asked if that meant he stopped getting care, E5 stated they never stopped giving care, he refused care, i.e. refused to get out of bed and go to the dining room. E5 stated remember on 4/7, R1 had no payer source and asked how PT can see him if there is no payer source. She felt the facility was going over their boundaries with having no payment for services. E5 asked this surveyor if S2 (foot doctor) knew that R1 had no payer source. This surveyor replied that S2 was under the impression that R1 was receiving PT here at the facility per his orders. E5 stated he was getting nursing care, but would not be entitled to physical therapy since the facility was not being paid.</p> <p>Review of the clinical record revealed that the facility failed to provide PT to R1 from 4/6/15 through 5/1/15 despite two physician orders dated 4/6/15 and 4/20/15 for PT.</p> <p>An observation on 5/8/15 at approximately 12:10 PM revealed a pink label on the</p>		

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	<p>outside of R1's chart, confirming E5's statement above.</p> <p>In an interview on 6/4/15 at 1:49 PM, E1 (NHA) stated the colored labels were used to assist the unit clerk to arrange services for residents, i.e. transportation, according to their payer source.</p> <p>The facility failed to ensure that R1 was not treated based on his source of payment when providing services. Findings reviewed with E1 and E2 (DON) on 6/4/15 at approximately 5:30 PM.</p> <p><u>F223</u> §483.13(b) Free From Abuse/Involuntary Seclusion</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>This requirement was not met as evidenced by:</p> <p>Based on observation, record review, interviews and review of facility documentation, it was determined that for one (R1) out of 3 sampled residents, the facility failed to protect R1's right to be free from abuse when R1 felt threatened and intimidated by a staff person in a supervisory role and deprived of goods and services when his requests for physical therapy, transfer assistance and a different staff person to wrap his leg were disregarded. Findings include:</p> <p>The facility's policy entitled "Abuse</p>		
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	<p>Prohibition", last revised on 12/1/11, stated, "... Adult abuse is defined as: ... Emotional abuse which includes, but is not limited to, ridiculing or demeaning a patient, making derogatory remarks to a patient ... or threatening to inflict physical or emotional harm on a patient ...".</p> <p>2/17/15 - R1 was admitted to the facility for short-term rehabilitation, including PT. Diagnoses included a right BKA, diabetes and hypertension. His admission weight was 305 lbs.</p> <p>2/24/15 - The admission MDS assessment stated that R1 was able to make his own decisions.</p> <p>Review of R1's clinical record from admission on 2/17/15 through 4/23/15 revealed the absence of grievances or complaints. In fact, nurse's notes during this timeframe captured R1 as able to make his needs known, pleasant, cooperative and thankful for care from staff.</p> <p>4/30/15 at 6:52 PM - Surveyors interviewed the resident, R1, in the presence of S6 (family member). R1 stated the following:</p> <ul style="list-style-type: none"> - He felt threatened and intimidated by E5 (UM, RN). - "The only issue I have is with one nurse (E5) and she is a 7 to 3 pm ... At 7:00 in the morning, I am on my guard at least." - He had been asking for assistance with transfers and asking for physical therapy the week of 4/27/15. He asked E5 for transfer assistance with a lift, which was refused. He asked E5 three (3) times to talk to PT. - "I have one leg to transfer with ... I think it is unsafe ... I am staying here (in his room) 		

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	<p>because ... unsafe transfer." - On 4/28/15 around lunchtime, E5 told him "you will be eating outside this room tomorrow". R1 interpreted this to mean that he may not receive his meal if he stayed in his room. R1 is a diabetic and requested that S6 bring him food. S6 delivered food but R1 also confirmed that his meals were delivered to his room by the facility. - "... I asked for a different nurse to wrap my leg ... she says 'it's either me or no one' ... she is stating that I refused which I have never refused." - E5 refused to provide her last name when asked. R1 has vision problems and was not able to read her name tag. - S6 (family member) stated, "... really bothered me was when E5 told me like three (3) weeks ago S1's (wound care doctor) order expired and that she was going to stop wrapping his leg, so I had to take R1 back to S1's office to get S1 to write a lifetime order because they (the facility) were supposed to wrap his leg here twice a day and they never did it ...".</p> <p>Review of R1's clinical record revealed the following: - Absence of grievances or complaints 2/17/15 - 4/23/15. - Lack of evidence that R1 was referred to or seen by PT from 3/13/15 - 5/1/15. - On 5/1/15, a formal complaint was submitted by S6 and R1 was seen by PT that day at which time it was determined that his self-transfers were not safe. - From 4/7/15 - 4/15/15, the facility failed to provide R1's leg wrap treatment for a total of 18 times. - A new order for the leg wrap was written by S1 on 4/15/15.</p>		
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	<p>- During the interview with R1 and S6, R1 stated that he recorded a conversation with E1 (NHA) on 4/30/15 at 11:49 AM. The surveyors listened to the recording, which revealed that R1 told E1 that he was having confrontations and felt this was a "hostile environment" with E5 and requested to be moved. E1 stated that he did not wish to be recorded but understood that R1 wanted some "memorial of the discussion". R1 stated, "I just want to make sure we are all on the same page. That we all understand each other and there is no misinterpretation and I think a recording does that perfectly."</p> <p>5/6/15 at 1:00 PM - The surveyors interviewed E15 (LPN), who stated he was the assigned floor nurse for R1 on 4/30/15 day shift. E15 stated he saw E5 in R1's room on 4/30/15 "as she starts treatments early after report". E15 counted his medications and then walked the hallway to check on his residents. As he was returning up the hallway, R1 was calling out E16's (another LPN) name. E15 walked into the room after hearing R1 call out. R1 was on his personal cell phone with 911, an outside emergency help line. R1 stated to E15 that 911 dispatch was on the phone and handed it to E15. E15 stated that R1 was flustered and told him he did not want E5 wrapping his leg. Despite R1 telling E5 on 4/27/15 that he did not want her in his room or to wrap his leg, E5 was seen in R1's room on 4/30/15, as witnessed by E15, and R1 felt that he needed to call 911 and did so.</p> <p>5/8/15 at 7:17 AM - The surveyors interviewed E5, who stated that she was the unit manager and in charge, and she also provided wound care treatments for her unit. The following issues were discussed with E5:</p>		

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	<p>- E5 stated that many times when she entered R1's room at 7:10 - 7:15 AM, he was already dressed.</p> <p>- When asked if R1 requested to speak to PT, E5 stated if he asked for it, it would have happened.</p> <p>- E5 stated that she went into R1's room on Monday (4/27/15) because staff reported he was refusing to transfer without a lift. E5 stated that R1 did not want her in there. E5 stated that she offered to manually transfer him with 4 staff people, and R1 refused. E5 stated R1 was being mean to her, yelling at her and telling her she was not following doctor's orders, which E5 said was a lie. E5 stated that R1 told her he could not tolerate weight bearing for transfers. When asked by this surveyor why the facility's in house PT was not consulted about R1's transfer status using the facility's Rehabilitation Referral form, E5 stated "Honestly, they (nursing) are not used to doing this if there is not a payer source. It all comes down to the non-payer source. They are not refusing care ... nursing can do therapy." E5 stated it was brought up in the leadership meeting on Monday (4/27/15). E5 stated it was recommended to her not to use a Hoyer lift. When asked who told her that, E5 stated no one was making the decisions, but the CNA's were uncomfortable with using the lift. E5 also stated she did not think it was safe to use a Hoyer lift, and it was her opinion, R1 would have done something to make himself fall out of it. E5 stated that nothing was mentioned by R1 until Monday (4/27/15) and he should have already been discharged. E5 stated they could pivot R1 and asked why they would need therapy for that. E5 stated he</p>		
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	<p>was demanding a Hoyer (lift) only ... "you just don't demand things". E5 stated that in the leadership meeting on 4/27/15, E1 asked her to get a script from S2 (foot doctor) that he can weight bear since R1 was asking for a Hoyer lift. E5 stated they were trying to figure out what to do with R1 as he was a very difficult patient. E5 stated at first that E8 (facility's doctor) asked her, but then changed and stated E1 and E2 (DON) asked her to see about getting a script from S2 to say he was cleared to be discharged. E5 stated that S2 would have to say from a podiatry point of view was yes, R1 was able to go home with home health care. E5 stated that she asked S2 to do it, but he did not have to write it. R1's clinical record revealed a 4/28/15 script faxed from S2, which stated "weight bearing as tolerated for physical therapy". In addition, S2 refused to write that R1 was cleared to be discharged from the facility.</p> <p>- When asked what was the facility's response when R1 became non-weight bearing, E5 stated, "You mean he was never picked up from PT from March to April? That's terrible ... can't believe PT is not involved." E5 was shown that there were 2 consultations written that never reached PT, E5 stated that was their fault. E5 stated there was a lot of breakdown in communication.</p> <p>- E5 stated she was interested in when R1 went from "skilled to pink". When asked what she meant, E5 explained that there was a color label on the outside of the resident's chart to indicate if there was a payer source or not. E5 stated green was managed care, yellow was Medicaid, blue was Medicare, white was private pay and pink was no payer source. E5 stated when R1's 30 days were exhausted (occurred mid-March) and he did</p>		
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	<p>not leave the facility, that's when E1 made him a non-payer source. E5 stated that when the nurses see a pink label, they feel they should not have to document since it's not a blue label. When asked if that meant he stopped getting care, E5 stated they never stopped giving care, he refused care, i.e. refused to get out of bed and go to the dining room. E5 stated remember on 4/7, R1 had no payer source and asked how PT can see him if there is no payer source. She felt the facility was going over their boundaries with having no payment for services. When asked about S2's (foot doctor) orders for PT, E5 stated that the consultation report was not an order. It was a recommendation until E8 (facility's doctor) approved it. E5 asked this surveyor if S2 knew he had no payer source. This surveyor replied that S2 was under the impression that R1 was receiving PT here at the facility per his orders. E5 stated he was getting nursing care, but would not be entitled to physical therapy since the facility was not being paid. E5 stated it was a major issue.</p> <p>- E5 stated that R1 told her he did not want her wrapping his leg anymore on Monday, 4/27/15. E5 stated "once he tells me I'm not allowed to change his ace, I'm not allowed to go in there anymore ... it was assigned to someone every day." When asked about R1's leg treatment, E5 stated that there should be a stop order until the patient was seen again by the doctor and had a new order to resume. E5 stated that R1 was very insulted when she asked R1 to ask S1 (wound care doctor) how he wanted the ace wrap to continue. E5 stated that she asked if they could discontinue it and R1 was very mad and said I have to have this (wrap). E5 stated that S1 wrote a lifetime order for R1's ace wrap and she did not understand why. When E5 was</p>		
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	<p>shown the April 2015 TAR and asked who signed R1's treatments off from 4/27/15 through 4/30/15, E5 confirmed she signed the TAR everyday and explained that the staff was bad about signing off and she checked them at the end of the day and filled in whatever was blank when she knew it was done.</p> <p>- When first asked about being in R1's room on 4/30/15, E5 denied being in the room. When asked again she said she did not recall being in R1's room. E5 denied having said to R1 that she would do the ace wrap or no one would do it. E5 stated it was all about the Hoyer lift.</p> <p>- When asked about refusing to give R1 her last name, E5 confirmed that she did not give her last name because he was being very ugly. E5 stated it was on her badge and in front of him. E5 stated if he could not see, he would not be on his cell phone or computer all day.</p> <p>- When asked if her interactions with R1 were ever heated, E5 stated no, but that she talks loud. She would never do that to him. When asked if R1 ever yelled at her, E5 stated yes. E5 stated that R1 would never admit to it, but he did.</p> <p>- When asked why did R1's situation rise to a point of the 911 call the morning of 4/30/15 if R1's issue of transferring was discussed frequently among the facility staff, E5 stated R1 needed to be out since his insurance ended and she did not understand why he wanted to stay, knowing that he could not pay.</p> <p>5/8/15 at approximately 12:10 PM - This</p>		
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	<p>surveyor observed a pink label on the outside of R1's chart, confirming E5's statement above.</p> <p>The facility failed to protect R1's right to be free from abuse when R1 felt threatened and intimidated by a staff person in a supervisory role and deprived of goods and services when his requests for physical therapy, transfer assistance and a different staff person to wrap his leg were disregarded. Findings were reviewed at the exit conference on 6/4/15 at 5:30 PM with E1 and E2.</p> <p>F224 §483.13(c) Prohibit Mistreatment/Neglect/Misappropriation</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property</p> <p>This requirement was not met as evidenced by:</p> <p>Based on record review, interviews and review of facility documentation, it was determined that for one (R1) out of 3 sampled residents, the facility failed to protect R1's right to be free from neglect when physician orders from two consultations on 4/6/15 and 4/20/15 were not followed and physical therapy was not provided. In addition, R1's physician order from S1 (wound care doctor) was not followed and treatment was not provided from 4/7/15 through 4/15/15 to wrap his left leg twice a day, a total of 18</p>		
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	<p>opportunities. Findings include:</p> <p>The facility policy entitled "Abuse Prohibition", last revised on 12/1/11, stated, "... Neglect is defined as: ... Failure to carryout a prescribed treatment plan for a patient ...".</p> <p>1a. Undated - S2's (foot doctor) consultation report stated, "... Ok for PT, WB as tolerated ...". This consultation report was reviewed and acknowledged by E8 (facility's doctor) on 4/7.</p> <p>4/20/15 - S2's consultation report stated, "... Start PT to (increase) strength L leg ... Ok for limited WB while in PT setting c supervision ...". This consultation report was reviewed and acknowledged by E7 (NP) on 4/20.</p> <p>5/5/15 at 3:10 PM - In an interview, E9 (PT Director) stated that he was not notified by nursing of the 4/6/15 and 4/20/15 physician orders for PT from S2. E9 stated the last time he saw R1 on a clinical basis was 3/13/15.</p> <p>5/6/15 at 7:53 AM - In an interview, E7 stated that consultation reports are orders from other doctors and they are to be followed and implemented. E7 expected that R1's order was being followed and that R1 was receiving PT.</p> <p>5/6/15 at 10:50 AM - In an interview, E14 (RN) stated that she received S2's consultation report from 4/6/15 and transcribed it to a physician's order and the TAR. E14 stated that she thought R1 was on PT's caseload and admitted that she did not notify PT of the new order.</p> <p>The facility failed to provide physical therapy as prescribed twice by S2 on 4/6/15 and</p>		

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	<p>4/20/15. Findings were reviewed during the exit conference on 6/4/15 at 5:30 PM with E1 (NHA) and E2 (DON).</p> <p>1b. 3/25/15 - R1 was seen by S1 for a left ankle wound. S1's consultation report stated, "... continue ... wrap and Bactroban BID (twice a day)."</p> <p>4/7/15 - A physician's verbal order from E8 stated to discontinue Bactroban as the left ankle wound had healed.</p> <p>Review of R1's April 2015 TAR revealed the absence of R1's treatment for a wrap BID was provided from 4/7/15 through 4/15/15, a total of 18 scheduled times. The April 2015 TAR revealed that when the Bactroban wound treatment was discontinued on 4/7/15 so was R1's prescribed wrap twice a day.</p> <p>4/15/15 - S1's consultation report stated, "... 1) Will need ... wrap every day. Off at bedtime ... Will need this dressing regimen for lifetime ... compression wrap used to treat swelling. Essential to prevent further wounds ...".</p> <p>4/30/15 - In an interview at 6:45 PM, S6 (family member) stated that E5 (RN) told her S1's order expired and E5 was not going to wrap R1's left leg. S6 stated that she told E5 that R1 had an order to wrap his left leg twice a day. S6 stated that she had to take R1 to another consult with S1 on 4/15/15 in order to obtain a lifetime order for a compression wrap.</p> <p>The facility failed to follow S1's physician orders for a compression wrap from 4/7/15 through 4/15/15, a total of 18 scheduled times. Findings were reviewed with E1 and E2 on 6/4/15 at 5:30 PM.</p>		

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	<p>F280 §483.20(k)(2)Right to Participate Planning Care/Revise CP</p> <p>A comprehensive care plan must be—</p> <p>(iii) Periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This requirement was not met as evidenced by:</p> <p>Based on record review, interview and review of facility documentation, it was determined that for one (R1) out of 3 sampled residents, the facility failed to review and revise R1's ADL care plan since 2/18/15 even after he experienced changes in transfer status. Findings include:</p> <p>The facility policy entitled "Care Plans", last revised on 1/2/14, stated, "... The comprehensive care plan is ... 2.4 Reviewed and revised ... as needed to reflect response to care and changing needs and goals ...".</p> <p>2/18/15 - R1 was care planned for "... exhibits or ... at risk for decreasing ability to perform ADL ... due to left leg cellulitis, deconditioning ...". An intervention included: "... Provide extensive assistance ... transfers ...". After 2/18/15, R1's transfer status changed four (4) times, i.e. extensive assist, limited assist, independent and non-weight bearing (total assist). Review of R1's clinical record revealed this care plan remained in place as of 5/1/15, approximately 2 1/2 months later, even when R1's weight bearing status affecting transfers changed.</p>		
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	<p>5/5/15 - In an interview at 11:12 AM, E4 (CRC) confirmed that R1's ADL care plan was not reviewed and revised. The facility failed to review and revise R1's ADL care plan to reflect changes in transfer status. Findings were reviewed with E1 (NHA) and E2 (DON) on 6/4/15 at 5:30 PM.</p> <p><u>F309</u> §483.25 Provide Care/Services for Highest Well Being</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This requirement was not met as evidenced by:</p> <p>Based on observation, record review, interviews and review of facility documentation, it was determined that for one (R1) out of 3 sampled residents, the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical well-being, in accordance with the plan of care. The facility failed to re-assess R1 after he became non-weight bearing on 3/18/15; failed to communicate with PT and implement the 4/6/15 physician's order for PT; failed to transcribe, communicate and implement the 4/20/15 physician's order for PT; and failed to provide physical therapy as ordered from 4/6/15 to 5/1/15, a total of 25 days. As a result, the 5/1/15 PT evaluation noted a decline in R1's</p>		
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**DELAWARE HEALTH
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Division of Long Term Care
Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Churchman Village

DATE SURVEY COMPLETED: June 4, 2015

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	<p>LE strength, poor standing balance, impaired transfers and pain on L foot upon weight bearing in contrast to his last PT evaluation on 3/13/15 where he was independent on transfers. In addition, R1's physician orders for wound care on 4/1/15 were not followed and provided from 4/7/15 through 4/15/15, a total of 18 scheduled times. Findings include:</p> <p>The facility's policy entitled "Transcription of Orders", last revised on 10/1/12, stated, "Orders from an authorized licensed independent practitioner (doctor) are transcribed by a licensed nurse ... Purpose: To communicate all practitioners orders to caregivers regarding patient's care and treatment."</p> <p>1a. R1 was admitted to the facility on 2/17/15 for short-term rehabilitation post hospitalization for cellulitis on the left lower leg and a wound on the anterior aspect of the left ankle. Diagnoses included BKA on right leg, hypertension, diabetes and peripheral neuropathy.</p> <p>2/17/15 - The Interagency Nursing Communication Record from the hospital stated that R1 was to weight bear to left foot with surgical shoe for transfers only.</p> <p>2/18/15 - R1 was care planned for "... exhibits or ... at risk for decreasing ability to perform ADL ... due to left leg cellulitis, deconditioning ...". An intervention included: "... Provide extensive assistance ... transfers ...". Review of R1's clinical record revealed this care plan remained in place as of 5/1/15, approximately 2 1/2 months later.</p> <p>2/18/15 - A physician's order stated that Occupational Therapy would evaluate and</p>		

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	<p>treat 5-6 times a week x 30 days.</p> <p>2/18/15 - The Occupational Therapy Initial Evaluation stated, "Patient referred to skilled OT due to new onset of impaired ADL performance, impaired balance, impaired functional activity tolerance, impaired functional mobility ... impaired strength and impaired transfers indicating the need for OT to increase I w/ADLs, facilitate dynamic standing balance, increase functional activity tolerance, increase safety awareness and facilitate sitting tolerance and postural control."</p> <p>2/19/15 - A physician's order stated that Physical Therapy would evaluate and treat 6 times a week for 30 days.</p> <p>2/19/15 - The Physical Therapy Initial Evaluation stated that R1's impairments were decreased lower extremity strength, impaired transfers and no ambulation secondary to precautions. The summary of findings stated, "... Based on his diagnosis, pt weight-bearing is limited to transfers only. While this will decrease time for wound healing, pt is unable to ambulate at this time. Mild LE weakness was discovered, which will only by (sic) augmented by the increased amount of time pt will be required to spend sedentary secondary to his WBing precautions."</p> <p>2/20/15 - The physician's admission history and physical stated that R1 was alert and oriented, had decreased vision, ambulatory dysfunction, decreased lower extremity sensation, left lower leg edema, severe stasis and a left lower extremity wound. The physician's plan was to continue with administration of two antibiotics for the left foot wound, local wound care treatment in</p>		

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	<p>addition to physical therapy and occupational therapy evaluation and treatment for ambulatory and ADL dysfunction.</p> <p>2/24/15 - The MDS assessment documented that R1 was able to make his own decisions and required limited assist of one staff person for transfers. This assessment was in contrast to the 2/18/15 care plan which required extensive assistance.</p> <p>2/25/15 - E8's (facility's doctor) progress note stated, "... L (left) foot ulcer (decreased) swelling & pain L foot edema (decreased) ... (decreased) LE sensation ... L foot cellulitis - Cipro + Augmentin (antibiotics) ... P. (peripheral) neuropathy - fairly advanced ... amb/ADL dys (dysfunction) - cont. (continue) PT/OT."</p> <p>3/13/15 - The Physical Therapy Discharge Summary stated all goals were met and under the summary of progress, "Pt currently I (independent) with all transfers and I with HEP for continued strengthening in order to prepare for gait activities once WBing precautions on LLE are lifted."</p> <p>3/13/15 - The Occupational Therapy Discharge Summary stated all goals were met.</p> <p>3/18/15 and timed 9:09 AM - E7's (NP) progress note stated, "... edema LLE ... left foot wound slowly healing ... amb dys wgt bearing for transfers bed to wc, independent with ADL ... no c/o pain ...".</p> <p>3/18/15 - R1 was seen by S1 (wound care doctor). The consultation report, mistakenly dated 3/16/15, stated "... Non weight bearing ...". The consultation report was reviewed and</p>		

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	<p>acknowledged by E7's initials and dated 3/19/15 and timed 8:00 PM - A physician's order was transcribed and stated, "D/C (discontinue) WB to L foot c surgical shoe transfers. Pt is NWB LLE." It is unclear from the clinical record as to why this order was never signed by the facility's doctor and how the facility responded when R1's status changed to non-weight bearing. The clinical record lacked evidence that R1 was re-assessed when he became non-weight bearing.</p> <p>3/25/15 - S1's consultation report stated, "... (2) no ambulation ...".</p> <p>Undated - S2's (foot doctor) consultation report stated, "... Ok for PT, WB as tolerated ...". This consultation report was reviewed and acknowledged by E8 on 4/7.</p> <p>4/6/15 and timed 10:35 PM - The undated S2's consultation report was transcribed to a physician's order, however, this order was never received by PT. The facility failed to provide PT despite a consulting physician's order to do so.</p> <p>4/20/15 - S2's consultation report stated, "Wound looks healed - Start PT to (increase) strength L leg ... - C/W (continue with) transfer - Ok for limited WB while in PT setting c supervision ...". This consultation report was reviewed and acknowledged by E7 on 4/20. It is unclear in the clinical record why the above orders were never transcribed as a physician's order and implemented. S2's second order to start physical therapy was never received by PT. The facility failed to provide PT despite a consulting physician's order to do so.</p>		

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	<p>4/20/15 - E7's progress note stated, "... seen by S2, wound looks healed ... edema LLE ... ok for limited WB ... keep LLE elevated ...".</p> <p>4/28/15 - Record review revealed a faxed copy of a prescription addressed to E5 (UM, RN) from S2 which stated, "patient is weight bearing (sic) as tolerated for PT". The facility failed to provide PT despite a consulting physician's order to do so.</p> <p>4/30/15 - Record review revealed a faxed copy of a prescription addressed to E12 (facility's unit clerk) from S3 (foot doctor's staff) which stated, "Pt cleared to WB L leg".</p> <p>4/30/15 and timed 2:00 PM - E12's typed statement in R1's clinical record stated, "Received call back from S3 ... S3 stated, 'He (S2) would not write a rx (prescription) for R1 to be discharged. That is our Medical Director's decision. He has already written a rx for full weight bearing.' E12 verbalized understanding of (S2's) decision & reiterated that R1 insisted this rx come directly from (S2) ...".</p> <p>4/30/15 - A physician's order stated that R1 was to bear full weight on LLE.</p> <p>4/30/15 - E8's progress note stated, "c/o (complaint of) L LE pain - asking staff to Hoyer lift him - called police to complain ... L good pedal pulse ... no edema L foot ... skin intact ... hoyer lift is inappropriate - D/W patient. L LE wound has healed. He has good pulses. There is no reason why he can't bear full weight on L LE. D/W ... podiatry & he agrees c my assessment. Full weight bearing ordered. D/W staff. Pt needs to go home! Medically stable for D/C (discharge)." R1 was</p>		

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	<p>not discharged. E8 ordered full weight bearing despite the fact that R1 had been non-weight bearing since 3/18/15 and despite the fact that R1 had not received PT for weight bearing as ordered twice by a consulting physician.</p> <p>5/1/15 - Two physician's orders stated that OT and PT were to evaluate and treat R1.</p> <p>5/1/15 and timed 2:10 PM - An observation was made of PT and OT assessing R1's range of motion, strength and transfers. R1 demonstrated how he was transferring himself from the bed to the wheelchair and vice versa. E9 (PT Director) stated, "This is different (referring to transfers) than when we evaluated you before." E9 and E10 (OT) stated that R1 was a good candidate for using a sliding board when transferring as they both agreed his self-transfer status was not safe.</p> <p>5/1/15 and timed 4:16 PM - The Occupational Therapy Initial Evaluation stated, "... Patient referred to skilled OT due to impaired ADL performance, impaired functional mobility and impaired transfers ... Pt previously on OT caseload from 2/18/15 to 3/13/15. Pt was d/c secondary to all goals met and was issued theraband UE HEP. Pt reports 'probably not as much as I should have' in re: to whether he has been completing HEP ... Pt unsafe during transfer. Pt does not WB through LLE ... PLOF = independent (at previous OT d/c) ... Pt reports pain 4/10 when he weight bears on L foot, 0/10 at rest ... Pt presents with decline in safety during transfers, slight decline in functional transfers, limited standing tolerance requiring skilled OT services to address. Recommend OT 3x/week in conjunction with UE HEP in order</p>		

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	<p>to increase I with toileting and functional transfers and to increase safety during transfers. Recommend OT cotreat with physical therapy for safety during transfers."</p> <p>5/1/15 and timed 4:41 PM - The Physical Therapy Initial Evaluation stated, R1's impairments were "pain on L foot upon wt bearing, poor safety awareness during transfers and poor standing balance". The clinical impressions were "Pt is noted with pain and muscle weakness on L foot upon wt bearing resulting to poor standing balance and increasing risk for falls ... Pt will benefit from skilled PT services to increase LE strength, improve balance, and complete transfers safely in order to decrease risk for falls, and allow patient to return home at highest functional level." The reason for the referral stated, "Patient demonstrates new onset of impaired transfers and pain indicating the need for PT to increase strength, promote safety awareness and reduce risk for falls ... Pt was previously on PT/OT caseload and was d/c secondary to meeting all goals. Pt is re-evaluated for PT/OT and services per consult with E1 (NHA) and E2 (DON)." This re-evaluation occurred after a meeting with DLTCRP.</p> <p>As noted by OT and PT on 3/13/15, "Pt. was d/c secondary to all goals met ..." and "... all goals were met ... Pt currently I with all transfers ...". On 5/1/15, however, OT and PT noted, "Pt unsafe during transfer. Pt does not WB through LLE ... Pt presents with decline in safety during transfers, slight decline in Functional transfers ..." and "... poor safety awareness during transfers and poor standing balance ... increasing risk for falls ... new onset of impaired transfers and pain ...".</p>		

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	<p>5/5/15 at 3:10 PM - In an interview, E9 stated that he was not notified by nursing of the 4/6/15 and 4/20/15 physician orders for PT from S2. E9 stated the last time he saw R1 on a clinical basis was 3/13/15 and he was independent with transfers.</p> <p>5/6/15 at 7:53 AM - In an interview, E7 stated that consultation reports are orders from other doctors and they are to be followed and implemented. E7 expected that R1's order was being followed and that R1 was receiving PT.</p> <p>5/6/15 at 9:50 AM - In an interview, E13 (LPN) stated that she did not write the 3/18/15 physician's order for non-weight bearing LLE, however she signed the order at 8:00 PM and transcribed it to the TAR. E13 stated that the Physical Therapy department was closed at that time and she slid it under PT's door. E13 then stated that she placed the original physician's order and S1's consultation report in the facility's doctor folder to be signed. E13 also stated that she passed on R1's non-weight bearing status in report to the next shift.</p> <p>5/6/15 at 10:50 AM - In an interview, E14 (RN) stated that she received S2's 4/6/15 consultation report that stated ok for physical therapy, weight bearing as tolerated and transcribed it to a physician's order and the TAR. E14 stated that she thought R1 was on PT's caseload and admitted that she did not notify PT of the new order. E14 stated that she placed the physician's order and S2's 4/6/15 consultation report in the facility's physician folder to be signed. E14 stated that she passed on R1's new orders to the next shift.</p>		
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	<p>5/6/15 at 12:03 PM - In an interview, R1 stated that he gave S2's 4/20/15 consultation report to E5 as he returned to the facility during day shift.</p> <p>5/6/15 at 2:51 PM - In an interview, E11 (PT) stated that she was covering the PT department when E9 (PT Director) was on vacation from 4/23/15 through 4/28/15. When asked if anyone on staff approached you from 4/23/15 through 4/28/15 about R1 asking to talk to E9 about transfer status and restarting PT, E11 stated "no".</p> <p>5/7/15 at 3:04 PM - In a telephone interview, S3 stated that this office received multiple calls from the facility's staff inquiring about scripts for R1's weight bearing status and discharge. S3 stated "We were under the impression that he had been there doing the physical therapy."</p> <p>5/8/15 at 7:17 AM - In an interview, E5 stated that the consultation reports are not actual orders and they have to call E8 to get her approval before they follow the consultant's recommendations.</p> <p>The facility failed to re-assess R1 when he became non-weight bearing on 3/18/15; failed to communicate with PT and implement the 4/6/15 physician's order for PT; failed to transcribe, communicate and implement the 4/20/15 physician's order for PT; and failed to provide physical therapy as ordered from 4/6/15 to 5/1/15, a total of 25 days. As a result, the 5/1/15 PT evaluation noted a decline in R1's LE strength, poor standing balance, impaired transfers and pain on L foot upon weight bearing in contrast to his last PT evaluation on 3/13/15 where he was independent on transfers. Findings were</p>		

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	<p>reviewed during the exit conference on 6/4/15 at 5:30 PM with E1 and E2.</p> <p>1b. 3/25/15 - R1 was seen by S1 for a left ankle wound. S1's consultation report stated, "... continue ... wrap and Bactroban BID (twice a day)."</p> <p>4/1/15 - S1's consultation report stated, "moisturize & wrap BID. Make sure wrap is applied correctly. Rectagles (sic) become square and should be seen all the way down". It is unclear in R1's clinical record as to why S1's order was not transcribed onto a physician's order sheet and the April 2015 TAR updated.</p> <p>4/7/15 - A physician's verbal order from E8 stated to discontinue Bactroban as the left ankle wound had healed.</p> <p>Review of R1's April 2015 TAR revealed that R1's treatment for a wrap BID was not provided for a total of 18 times from 4/7/15 through 4/15/15. The April 2015 TAR revealed that when the Bactroban wound treatment was discontinued on 4/7/15 so was R1's prescribed wrap twice a day.</p> <p>4/15/15 - S1's consultation report stated, "... 1) Will need ... wrap every day. Off at bedtime ... Will need this dressing regimen for lifetime ... compression wrap used to treat swelling. Essential to prevent further wounds ...".</p> <p>4/30/15 - In an interview at 6:45 PM, S6 (POA) stated that E5 told her S1's order expired and E5 was not going to wrap R1's left leg. S6 stated that she told E5 that R1 had an order to wrap his left leg twice a day. S6 stated that she had to take R1 to another consult with S1 on 4/15/15 in order to obtain</p>		

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	<p>a lifetime order for a compression wrap.</p> <p>The facility failed to follow S1's physician orders for a compression wrap from 4/7/15 through 4/15/15, a total of 18 scheduled times. Findings were reviewed with E1 and E2 on 6/4/15 at 5:30 PM.</p> <p>F514 §483.75(l)(1)Resident Records-Complete/Accurate/Accessible</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systemically organized.</p> <p>This requirement was not met as evidenced by:</p> <p>Based on record review, interview and review of facility documentation, it was determined that for one (R1) out of 3 sampled residents, the facility failed to maintain R1's clinical record in accordance with accepted professional standards and practices that are complete and accurately documented. Findings include:</p> <p>The facility policy entitled, "Nursing Documentation", last revised on 10/1/12, stated, "... Documentation for subsequent and/or routine care and procedures may be completed by ... the use of a checklist, flow charts, or other documentation tools ... Purpose: ... provide accurate accounting of care and monitoring provided ... Nurses will not: 1.1 Document services that were not performed; 1.2 Document services before</p>		

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	<p>they are performed ...".</p> <p>1. In an interview on 5/8/15 at approximately 10:00 AM, E5 (UM, RN) admitted to signing off R1's leg wrap treatment on the April 2015 TAR from 4/27/15 through 4/30/15 when she did not perform the treatments.</p> <p>2a. R1's TAR revealed that he was ordered to receive treatment to his left ankle twice a day. Review of R1's TARs revealed the following incomplete documentation: - March 2015 - ten (10) out of 54 scheduled opportunities lacked documentation; - April 2015 - four (4) out of 12 scheduled opportunities lacked documentation.</p> <p>2b. Review of R1's April 2015 TAR revealed that he was ordered to have an ace wrap removed at night. Six (6) out of 16 scheduled opportunities lacked documentation to indicate completion of this task.</p> <p>3. The facility's policy entitled "Transcription of Orders", last revised on 10/1/12, stated, "Orders from an authorized licensed independent practitioner (doctor) are transcribed by a licensed nurse ... Purpose: To communicate all practitioners orders to caregivers regarding patient's care and treatment."</p> <p>Review of R1's clinical record revealed that a 4/20/15 consultation report from S2 (foot doctor) with orders for the following were not transcribed onto a physician's order sheet: - Start PT to increase strength left leg; - Continue with transfer; - Ok for limited WB while in PT setting with supervision; and - No left leg dependency over 15 minutes.</p>		

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	The facility failed to maintain a clinical record for R1 that was complete and accurately documented. Findings were reviewed during the exit conference on 6/4/15 at 5:30 PM with E1 (NHA) and E2 (DON).		

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